Screening for Burnout in Emergency Medicine Residents: Now What?

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Burnout is a pervasive threat to medicine, and as a specialty, we need to take a hard look at why emergency medicine (EM) repeatedly demonstrates the highest rates of burnout in the house of medicine. More importantly, we need to correct this. More than two-thirds of emergency physicians surveyed are reporting burnout.[1] This threatens our front-line providers, patients, and healthcare system.[2,3]

The study by Drs. Lu, Lank, and Branzetti in this issue again demonstrates that for many learners, burnout starts early in their careers and that we, as faculty, do a poor job of identifying those who are burnt out. In their cohort, responding residents had an overall burnout rate of 70%, slightly higher than the 60% reported in a national study of trainees in all specialties[4] and similar to the overall rate of burnout in practicing emergency physicians.[1] Burnout impacts trainees' professionalism, empathy, patient care, and overall view of medicine.[5] Early erosion of these critical elements has long-term implications and detecting distress early may allow for targeted secondary interventions that not only mitigate its acute effects, but also promote a long-term view of medicine as a calling, that fosters a healthier long-term career.[6]

The findings by Dr. Lu et al. highlight several important facts and lead to even more questions. First, the authors show that we still grossly underestimate burnout in our colleagues, as even faculty advisors were unable to identify burnout in their advisees. Most physicians approach medicine as a calling and, as such, the needs of the patient trump any personal ones. Regardless of how exhausted, frustrated, or cynical internally, physicians develop strategies to professionally carry on. Yet burnout leads many to self-medicate[7,8] or resort to other forms of self-harm and this lack of recognition prevents meaningful interventions. Second, we need objective tools to identify trainees experiencing burnout. Studies suggest that individual physicians do not accurately calibrate their own level of burnout/distress.[9] This is a major limitation to strategies intended to enhance support to only those identified as being at risk. We need to identify those in distress early, before patient care is impacted or it results in serious personal ramifications for the individual.

The authors' findings along with prior data suggest that physicians are poor judges of burnout in their colleagues and themselves and also raise the question of whether we need broad-based screening for burnout in trainees. This finding leads to many further questions, including: Should screening be mandatory? What should we be screening for? How would the results be used? How will confidentiality be preserved/protected? Screening is only useful if we can affect the items we are identifying and develop secondary prevention strategies to halt progression.[9] While burnout is one potential outcome, one could make similarly cogent arguments for screening for depression, fatigue, stress, unhealthy behaviors, poor coping skills, or any of the myriad other markers of "distress." Regardless of how we define it, we cannot assume that individuals can identify distress in themselves or their colleagues and we need appropriate screening tools. New common program requirements from the

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Accreditation Counsel for Graduate Medical Education will require programs to offer access to self-screening and ensure that learners can identify and seek care for burnout in themselves or colleagues. These are a step in the right direction but identification is not enough, and training programs will need to be equipped to intervene once they identify those in distress.

To address burnout and improve well-being, we need to develop and deploy best practices to promote individual wellness and resilience while implementing organizational strategies toward the same.[10] One study found that simply providing surgeons normative feedback on their well-being prompted them to make changes to improve their well-being; with the greatest impact on those exhibiting the most distress,[9] providing some hope that feedback based on screening alone may be helpful. For individuals exhibiting high levels of distress, we need to offer resources to help them manage it, while maintaining their privacy and ensuring these results are not used punitively, on a departmental, organizational, or licensure level. We also need to examine those among us with low burnout scores and identify protective skills that can be developed and diffused. On a specialty level, we need to identify modifiable features of EM practice that contribute to burnout and address them on systemic levels.

Addressing burnout in EM will require a robust research agenda and an organized, multifaceted approach, using both structural and individual interventions. We know that burnout is pervasive[1] in EM and that various strategies can have an incremental impact.[11] However, there is much we do not know, including what makes EM different, what are the strongest contributors, which interventions (e.g. scheduling or staffing innovations) are protective, and which personal strategies are effective for individuals.

Emergency medicine is undoubtedly a high-stress specialty and the high rate of burnout is multifactorial. Early identification of those at greatest risk for burnout may allow for targeted interventions, both to modify controllable extraneous contributors and to also help individuals develop the skills they need to promote a long healthy career. There is much to be done, however, to determine which interventions will move the needle. Burnt-out providers cannot effectively and sustainably deliver high-quality care.[2,3] To promote the workforce of the future, we need to determine how to move from the triple to the quadruple aim and identify interventions to not only promote health, satisfaction, and value for our patients, but to also ensure the well-being and sustainability of our front-line providers.[12]

References

1. Shanafelt TD, Hasan O, Dyrbye LN, et al. Changes in burnout and satisfaction with work-life balance in physicians and the general US working population between 2011 and 2014. Mayo Clin Proc 2015;90:1600–13.
2. Dyrbye LN, Shanafelt TD. Physician burnout: a potential threat to successful health care reform. JAMA 2011;305:2009–10.
3. Lu DW, Dresden S, McCloskey C, Branzetti J, Gisondi MA. Impact of burnout on self-reported patient care among emergency physicians. West J Emerg Med 2015;16:996–1001.
4. Dyrbye LN, West CP, Satele D, et al. Burnout among U.S. medical students, residents, and early career physicians relative to the general U.S. population. Acad Med 2014;89:443–51.
5. West CP, Shanafelt TD, Kolars JC. Quality of life, burnout, educational debt, and medical knowledge among internal medicine residents. JAMA 2011;306:952–60.
6. Jager AJ, Tutty MA, Kao AC. Association between physician burnout and identification with medicine as a calling. Mayo Clin Proc 2017;92:415–22.
7. Jackson ER, Shanafelt TD, Hasan O, Satele DV, Dyrbye LN. Burnout and alcohol abuse/dependence among U.S. medical students. Acad Med 2016;91:1251–6.
8. Oreskovich MR, Shanafelt T, Dyrbye LN, et al. The prevalence of substance use disorders in American physicians. Am J Addict 2015;24:30–8.
9. Shanafelt TD, Kaups KL, Nelson H, et al. An interactive individualized intervention to promote behavioral change to increase personal well-being in US surgeons. Ann Surg 2014;259:82–8.
10. Shanafelt TD, Noseworthy JH. Executive leadership and physician well-being: nine organizational strategies to promote engagement and reduce burnout. Mayo Clin Proc 2017;92:129–46.
11. West CP, Dyrbye LN, Erwin PJ, Shanafelt TD. Interventions to prevent and reduce physician burnout: a systematic review and meta-analysis. Lancet 2016;388:2272–81.
12. Bodenheimer T, Sinsky C. From triple to quadruple aim: care of the patient requires care of the provider. Ann Fam Med 2014;12:573–6.